# TRANSACTIONS

OF THE

# AMERICAN DERMATOLOGICAL ASSOCIATION

AT THE

## NINTH ANNUAL MEETING

HELD AT

## INDIAN HARBOR HOTEL, GREENWICH, CONN.

ON THE

26th, 27th, and 28th of August, 1885.

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*Official Report of the Proceedings by the Secretary,*
W. T. Alexander, A.M., M.D.

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NEW YORK
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# TRANSACTIONS

OF THE

# AMERICAN DERMATOLOGICAL ASSOCIATION.

## NINTH ANNUAL MEETING.

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*Wednesday, August* 26—*Morning Session.*

The President, Dr. W. A. Hardaway, in opening the proceedings, said that, although he had no formal address to make, he felt that all would agree with him that great good had been accomplished in the work for which the Association, was established since its preliminary organization ten years ago. It had been fertile for good in furnishing a stimulus to the study of dermatology, and had been especially valuable to those of its members who lived at a distance from the greater medical centres. Although interest in the meetings had at times seemed to flag, he felt that the Association would continue to prosper, and that its success was now assured.

He expressed the pleasure it gave him to once more look upon the faces of the older members, extended a hearty welcome to the new members, and declared the meeting open for its regular scientific work.

The first paper was read by Dr. J. E. Graham. It was entitled:

### A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.

The patient was a girl 16 years old. When first seen, the disease had been in existence between four and five years, and had during that time gradually increased. It commenced a little above the right wrist, and extended over the forearm and elbow to the middle third of the arm.

The ulceration was followed by cicatrization. Another ulcer existed beneath the left clavicle.

The patient was put under antisyphilitic treatment, hydrargyrum bichloride and potassium iodide, together with the local application of a mild mercurial ointment. An immediate improvement took place, and in about two months the ulceration had entirely healed.

The case presented the following points of interest:

1. The extensive nature of the disease. It had not been treated for syphilis, and had consequently spread.

2. The ulceration appeared when the patient was twelve years of age. She had not, so far as could be learned, had any early manifestation of syphilis.

3. She inherited the disease from her father, who was known to have had syphilis. Her mother remained healthy.

4. The great difficulty in making a diagnosis between syphilis and scrofuloderma, as at first no syphilitic history could be obtained.

### DISCUSSION.

DR. TAYLOR expressed the belief that it is now generally conceded that syphilis can be communicated to the child by the father without infection of the mother, a view which he was the first to advocate in America, although it had long been rejected by many well-known authors. He thought that the case reported was undoubtedly such a one. He and his colleagues, at Charity Hospital, Blackwell's Island, had made repeated and thorough examinations of mothers who had recently given birth to syphilitic children, without finding the slightest evidence of the existence of the disease in them.

An interesting circumstance brought out by the paper was the absence of early symptoms of the disease in the girl. This is often stated in histories of such cases, but he felt confident that the assertion was not well founded, in view of the ease with which a slight coryza, roseola, or onychia might be overlooked. He believed that there must be some early manifestation of the disease in all cases. Deep ulcerative lesions may develop in such children as early as the age of six months, but they did not do so always. His experience had taught him that, while serious lesions, such as gummata, might develop during the first year of life, they might also remain away until the age of fourteen or eighteen years.

Another important point illustrated by the case was the effect of traumatism in furnishing a starting-point for the evolution of hereditary syphilitic lesions. He cited the case of a boy suffering from hereditary syphilis, in whom a wound of the leg by a stick had been followed by deep ulceration of specific nature. He thought the arguments advanced in the paper conclusively established the syphilitic nature of the malady. It is often impossible to accurately determine the nature of certain ulcerative processes from a limited number of examinations of the patient, a careful study of the family history and the concomitant symptoms being essential, and in many cases, the results of the internal treatment must be taken into account, in order to reach a satisfactory conclusion.

DR. GREENOUGH said that he had recently seen a striking case which went to establish the truth of the doctrine that the father could infect the child without giving the disease to the mother. It was that of a woman who had given birth to three children in succession, all of whom had died from a pemphigoid syphilitic eruption breaking out a few weeks after birth, the woman herself remaining perfectly healthy as far as he could ascertain, during several years' observation.

DR. HEITZMAN said that, in cases similar to the one reported, which were common, it is often impossible to make a diagnosis between syphilis and scrofula. He had recently seen a young man with an extensive ulceration, ten inches in diameter, in the groin. He had been unable to make a diagnosis at the first interview, and told the patient so. He had never seen him since.

DR. WHITE thought that local treatment alone often cured such lesions as those described by Dr. Graham and illustrated by the photographs shown, and he did not think it safe to base a diagnosis between syphilis and scrofuloderma upon the effect of combined treatment. Diagnosis was, in fact, often a matter of extreme difficulty in such cases, and he had had many patients whose disease he was firmly convinced was syphilis, although unable to advance any valid evidence for his belief. It seemed to him possible for the throat disease in the father of Dr. Graham's patient to have been of a scrofulous nature.

DR. GRAHAM said that the physician who had treated the throat affection had pronounced it syphilitic.

DR. DUHRING also alluded to the great difficulty of making a diagnosis in such cases as that of Dr. Graham. The result of the treatment, however, inclined him to believe the case one of syphilis. He thought the complete cure in so short a time as two months very remarkable. This fact also spoke in favor of the case being one of syphilis rather than scrofula.

DR. HYDE said that since he had written on the subject, he had seen a number of cases of children, born syphilitic, in whom most careful examination of the mothers showed no signs of the disease. These cases, however, had not taught him to go as far as Dr. Taylor, who had spoken of vigorous women bringing forth syphilitic offspring, as almost all the mothers were in delicate health.

He had never seen inherited syphilis develop for the first time in advanced life, and was unable to believe in the existence of a tardy inherited syphilis.

Alluding to the stress laid in the discussion upon the history of cases, he remarked that the more he saw of the disease, the less importance did he attach to the histories given by patients. The disease was so common that accidental cases were of frequent occurrence. One case came into his thoughts at the moment, in which he was satisfied that an ulcerative lesion on the penis was caused by inoculation from the hand of a syphilitic surgeon during the introduction of a catheter.

DR. HARDAWAY thought it a poor rule in practice to pin our faith upon the results of treatment. Such lesions as those described in the paper were often cured by local treatment alone; hence the fact that they disappeared under combined internal and external treatment was no proof of their syphilitic nature.

**Dr. Taylor** said that he also did not regard treatment as "la pierre de touche" of diagnosis. A careful study of all three factors—family and clinical history, and the results of treatment—is of importance.

He did not agree with Dr. Hyde, that mothers (of syphilitic children) in whom no positive evidence of the disease could be found, were generally in delicate health, since he had repeatedly seen robust buxom women bring forth such children. They might wither and become pallid afterwards, of course, but not necessarily from syphilis.

**Dr. Graham** said that it had been found impossible to make a diagnosis in his case until after treatment.

**Dr. Greenough** then read a paper entitled

## CLINICAL NOTES ON PSORIASIS.

It was based on the observation of 394 cases of the disease, which occurred in a number of about 15,000 of general skin disease, or in the proportion of a little over 2½ per cent. 205 cases were in male subjects, and 188 in female.

The ages of the cases when first seen were:

| | | | |
|---|---|---|---|
| Under 10 years, | 21 | From 40 to 50, | 42 |
| From 10 to 15, | 33 | Over 50, | 50 |
| “ 15 to 20, | 47 | | —— |
| “ 20 to 30, | 129 | | 394 |
| “ 30 to 40, | 72 | | |

In 44 cases the patients were seen during the first attack of the disease. Their ages were:

| | | | |
|---|---|---|---|
| Under 10 years, | 7 | From 30 to 40, | 6 |
| From 10 to 15, | 5 | “ 40 to 50, | 5 |
| “ 15 to 20, | 6 | Over 50, | 1 |
| “ 20 to 30, | 14 | | |

In 107 cases reliable testimony as to their age at the time of the first outbreak of the disease was obtained, and it was:

| | | | |
|---|---|---|---|
| Under 10 years, | 13 cases | From 30 to 40, | 13 cases |
| From 10 to 15, | 30 “ | “ 40 to 50, | 5 “ |
| “ 15 to 20, | 15 “ | Over 50, | 5 “ |
| “ 20 to 30, | 26 “ | | |

The 151 cases in which the date of the first attack could be determined, *i. e.*, 44 seen during first attack, and 107 when a reliable report of age at time of first attack could be obtained, gave the following statistics:

| | | | |
|---|---|---|---|
| Under 10 years, | 20 cases | From 30 to 40, | 19 cases |
| From 10 to 15, | 35 “ | “ 40 to 50, | 10 “ |
| “ 15 to 20, | 21 “ | Over 50, | 6 “ |
| “ 20 to 30, | 40 “ | | |

From these tables a large proportion of the cases proved to be first attacked by psoriasis between the ages of 10 and 40, which is what would be expected from the investigations of other observers; but the fact that, out of 151 cases, 20 showed symptoms of psoriasis before the age of 10, was not in accordance with previous experience; and that 6 cases should have been exempt from the disease for the first 50 years or more of their life, was still more at variance with preconceived notions. In 97 cases he had been able to get what appeared to be reliable testimony as to the existence or not of an hereditary tendency. In 31 of these, psoriasis probably had attacked some one of the patients' near relations, and in 66 the patients felt quite sure that such was not the case. This would give the proportion of cases where definite knowledge on the subject was shown as proving the existence of an hereditary influence in about one-third of the number of cases.

The instances in which the writer's observation had confirmed the generally accepted ideas on the subject were referred to, and cases in which he had found difficulty in diagnosis were reported, as was also his experience in treatment.

## DISCUSSION.

Dr. Hyde, having been told that none of Dr. Greenough's cases had the eruptions on the palms of the hands, said that he himself had never heen a case in which the eruption existed on these parts alone. He had seen cases on bald heads, where the patches showed a decided preference for the still hairy portions, never extending more than half an inch beyond the limits of the hair. Itching was, in his experience, often one of the most distressing symptoms of the affection. He had slso often observed that the patches were quite as well developed over the sacrum as on the extensor surfaces.

Dr. Duhring alluded to the omission of the reader of the paper to make any mention of the difficulty often met with in making a differential diagnosis between seborrhœa capitis and psoriasis confined to the scalp. In cases of young girls, he himself often found great trouble in making the diagnosis; and several cases which he pronounced to be seborrhœa had afterwards proved to be psoriasis.

Dr. Robinson said that, although he agreed with nearly all the statements made by the author of the paper, he would take exception to one or two. He thought that a diagnosis between psoriasis of the scalp and favus was not difficult. When a favus crust is removed, the surface is, as a rule, found to be shiny and depressed, not raw and granular, as was stated in the paper. The latter condition was encountered only in the later stages of favus.

He thought that Dr. Greenough was right when he stated that psoriasis begins as a small rose-colored non-scaly spot. Auspitz taught that psoriasis is primarily an affection of the corneous layer, while he himself held that it is a congestion of the rete.

As regarded pigmentation, he believed that while psoriasis often does pass away without it, yet, when it occurs on the legs, pigmentation often remains after its cure, particularly when varicose veins are also present. He thought that in many cases it is impossible to make a diagnosis between eczema and psoriasis on the legs, for, if the veins are varicose, the scales of the psoriatic patches often look like those of eczema. Very acute psoriasis often resembles acute eczema closely. He once made sections of skin from a case which he took to be one of eczema, and was much puzzled to find the characteristic histological changes of psoriasis, an instance of which disease it afterwards proved to be.

He thought that psoriasis unquestionably does occur on the palms, associated, of course, with the disease in other parts. On the palms it presents no elevated masses of scales, but simply thickening of the skin, the patches being sharply limited. He had also seen patches of psoriasis on cicatricial tissue, and had preserved specimens from such a case.

DR. WHITE said that to his mind one of the most striking peculiarities of psoriasis of the scalp was the difficulty with which it could be distinguished from dandruff, and that doubt as to the true nature of an eruption situated on this part must often be felt for a long time. This is not the case, of course, when the disease extends beyond the limits of the scalp, when the amount of scale-formation varies according to the personal habits of the patient.

In his experience, pigmentation was often very marked after old psoriasis, not only on the legs, but over the entire body, and he had seen it almost as pronounced as the discoloration left after lichen ruber.

He attached but little importance to the seat of the eruption, and was accustomed to place no reliance upon its location as an aid to diagnosis. In his experience the patches were often as abundant on the flexor as on the extensor surfaces, and when they were few in number they were most abundant on the extensor surfaces.

One point which had not been mentioned in the paper was the fact that psoriasis sometimes terminates in verrucous new growths, and these in epithelioma.

DR. MORISON, alluding to the circumstance that only one of Dr. Greenough's patients was a negro, said that he himself had seen only two cases of the disease in persons of that race. In those, loss of pigment had followed the disappearance of the patches.

DR. FOX had seen an extensive eruption of psoriasis in a child three and a half years old. He had also seen a case in which the body was covered with the disease, and the extremities were free. He thought that too much stress was ordinarily laid upon the location of the patches, on the knees and elbows, which, in many cases, are about the only parts spared. Too much stress was also laid upon the "robust health" of the victims of psoriasis, and he had observed that even in seemingly healthy persons the disease always grew worse when their general condition became bad; or, if women, when they became pregnant.

He had found the treatment of the disease much more satisfactory than that of many other cutaneous affections, and he always bore in mind the injunction of the late Tilbury Fox, that "the first thing to do in this disease is to lessen the congestion of the skin." For this purpose he gave alkaline diuretics, although he did not believe in "the gouty diathesis," and thought that the persistent use of large doses of alkalies often did more harm than good. He usually ordered a restricted diet, particularly as regarded meat, especially in hot weather. He also forbade tea, coffee, beer, and tobacco, and advised the liberal consumption of fruit and vegetables. He found that by this course he did more good than by prescribing arsenic or using active local treatment from the start.

As regarded local treatment, he would at present never think of using tar in psoriasis, believing that chrysarobin, used at the right time, was the best of all remedies. It should never be used when the patches were congested and might then cause the disease to spread. In case it did, he believed small doses of calomel and a restriction of the diet until the congestion was lessened would be the best plan of treatment. In many dispensary cases, in whom this plan of treatment had produced no better results than others, he had found that it would soon overcome the disease where the patients were taken into the hospital, where he could be certain that his orders were obeyed.

DR. HEITZMAN said that the most important point to be considered when beginning the treatment of a case of psoriasis was to ascertain whether the disease was acute or chronic. If acute, local treatment should not be resorted to. If chronic, the prospect of removing (not curing) the disease, by local treatment, was good. He had found that the eruption did itch sometimes, and that it occasionally occurred in persons in delicate health.

As regarded the etiology, he thought that even a simple miliaria might run into psoriasis, and he had seen one case in which the simple pressuer of the edge of a book held in the hand had caused an eruption of the disease at the spot pressed upon. He did not believe in the causative efficiency of "over-acidity," or of "the gouty diathesis," and thought that we were at present absolutely ignorant as to the true cause of the disease.

As regarded treatment, he thought that alkalies would sooner or later poison the stomach, and never used them. In acute cases he was in the habit of forbidding meat, and using very mild local treatment, often nothing more than an ointment of boracic acid. He could not agree with Dr. Fox in discarding tar for chrysarobin in chronic cases. The latter undoubtedly does remove the disease in some cases, but he agreed with Jarish that it often hastened its recurrence. He frequently employed tar after chrysarobin with the best results. The disease he thought a very unpleasant one to treat, on the whole; in some cases, especially the acute ones, it would continue to extend in spite of all treatment. A particularly obstinate form of the disease was one which Tilbury Fox had spoken of as a scrofulous psoriasis, occurring in sickly persons, a form of the affection in which the patches were small and scattered, and covered with thin scales. He recalled to mind one case of this kind, at Kaposi's clinic, in which the latter hesitated at making a diagnosis between eczema and psoriasis.

DR. TAYLOR also thought that dermatologists were too apt to magnify chrysarobin as compared with tar in the treatment of this disease. In his opinion the former should be used only in cases in which the disease was chronic and localized, and not in the congestive variety In some cases he had recently had under observation at Charity Hospital he had replaced chrysarobin with oil of cade with very decided benefit. He was convinced that a reaction in favor of tar in the treatment of psoriasis would ere long set in.

DR. HARDAWAY, speaking of the etiology of the aection, said that it was generally admitted that it was often hereditary. He thought that a peculiar kind of skin might be inherited in the same way as a peculiar color of the eye, and that if such were the case, almost any exciting cause, *e. g.*, traumatism, might lead to the development of the disease. He had seen an eczema persist for months and finally terminate in psoriasis; and he had seen an eczema clear up and leave islands of psoriasis behind, and he did not think it remarkable that psoriasis should follow seborrhœa, on account of the prolonged irritation attending the latter affection. Internal causes might excite psoriasis, and he had seen two patients develop the disease after the inordinate use of oatmeal. In its capacity for being excited by internal causes, the disease resembles eczema. In many instances the border line between the two diseases is very indistinct. Wise treatment of psoriasis, he thought, mainly looked towards diet. He restricted the use of meat, aided digestion, etc. Arsenic was useful in some cases, not from its power to remove any internal cause, but from its effects upon the skin itself. Locally, he had found chrysarobin very useful, especially mixed with salicylic acid, as recommended by Fox, particularly in chronic cases. He had used tar but little, but often used a sulphur ointment, especially after chrysarobin.

Dr. Fox, in answer to a question, said that he added the salicylic acid to the mixture of chrysarobin and collodion, because it softened the epidermic cells. He had found the preparation to act better thus.

DR. WHITE then read a paper on cases of

## ANGIOMA PIGMENTOSUM ET ATROPHICUM.

It contained the report of two cases of this rare disease. The patients were brothers, aged fifteen and three respectively, of Russian-Polish family. In the older, the affection exhibited in a striking manner its three principal pathological features, an almost universal lenticular melano-derma, large areas of atrophic integument, and a considerable development of telangiectasiæ. So far as could be judged by the study of these cases, the process is primarily a melasma, the atrophia cutis and new growth of blood-vessels being sequelæ and very subordinate processes in extent.

In the child of three years, the disease was confined to tho face and hands, and was represented only by the melano-dermic condition. In neither case was there an apparent beginning of the epitheliomatous change in the skin which so generally forms the last step in this mysterious series of pathological processes.

### DISCUSSION.

DR. TAYLOR was entirely at variance with Dr. White as to the relations of the little red spots to the macules, and he spoke from the experience of seven cases observed over an area of years. He had carefully marked the locations of the lesions, and had watched the fading of the red spots and the appearance of brown ones in their places. The only safe way to draw conclusions about this disease was to watch it from its commencement. The history is usually first an obscure rash, then little red spots, and last the macules. He was absolutely certain that the maculation followed the hyperæmia.

DR. HEITZMAN said that in three cases he had studied, the connection between the hyperæmia and the macules was as Dr. Taylor had stated.

DR. GREENOUGH had seen two of Dr. White's cases. In the younger there was no evidence of angioma, the appearance being entirely pigmentary, all stages of discoloration being present. Neither was there any history of vascular dilatation. It did not seem possible to him that each of the pigmented spots had been preceded by telangiectasis.

DR. TAYLOR said that in his cases the telangiectases were not always visible, appearing only when the parts were exposed to heat.

DR. FOX thought that the two processes of vascular dilatation and pigmentation were entirely distinct, and that it would be better to choose a meaningless name for the disease than the one used.

DR. WHITE said that he recognized a great variation in this disease according to the particular case, but must insist on the correctness of his own observations. He had observed the cases in hot rooms on very hot days, but never found any hyperæmia or chronic enlargement of vessels in the younger case. In the older case there was, at spots, no pigmentation, and there was also no enlargement of vessels. Although the three processes, permanent enlargement of vessels, pigmentation, and atrophy may be associated, they have, as far as individual lesions are concerned, no connection whatever, as far as his observation went.

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### *First Day—Evening Session.*

DR. HYDE read a paper on the

### RELATIONS OF LUPUS TO TUBERCULOSIS.

The author began with a tabulated statement of all the cases of lupus vulgaris reported to the Statistical Committee of the American Dermatological Association during the last seven years; and compared the frequency of the disease as recognized in this country with that reported from the Vienna hospitals, adducing reasons for believing that the American figures furnished a fair index of the relative preponderance of the disease as it exists in this country.

He then gave details of twenty cases of lupus vulgaris observed by him in Chicago, being the last twenty recorded in consecutive order.

Clinical deductions from these records were then added, showing, according to the author, that there was a remarkable absence in the family record of the twenty patients of cases of pulmonary tuberculosis, scrofula, and allied affections.

The teachings of the two schools, represented in the past by prominent German and French authors, were then reviewed, and finally the later investigations of the subject described, demonstrating that lupus vulgaris was the result of bacillus infection, not to be differentiated in the external characteristics of the parasite from bacillus tuberculosis.

The following clinical facts were then cited in support of the later teaching on this subject, as bearing on the vital point in the author's argument, viz. : that lupus vulgaris was not the result, as has long been taught, of a tuberculosis or other systemic diathesis, but was the product of a local infection by bacilli, entirely unassociated with any constitutional vice, diathesis, or predisposition.

1. The unimpeachable character of the family record in by far the larger number of all cases of lupus vulgaris.
2. The fact that the disease is, in its inception, a disorder of the period of childhood, when, for the most part, the habits of the child are favorable for infection.
3. The several sites of predilection of the disease are those most liable to such infection.
4. The failure of the disease to spread by inheritance.
5. The remarkable tendency of lupus vulgaris to a cutaneous limitation.

DR. WHITE read a paper on

### THE TREATMENT OF LUPUS BY PARASITICIDES.

In this communication he sketched the recent developments in our knowledge which established the common and bacillous origin of tuberculosis, scrofulosis, and lupus, and the rational attempts which have followed to overcome the latter phase of the disease by the external use of parasiticides. He reported the results of these methods in twelve cases of the disease which had been under his observation during the past eighteen months. From these experiments he concluded that we may probably be able to substitute for the painful and unsatisfactory surgical methods hitherto employed against the disease, such very simple applications as are capable of destroying the bacilli in the lupus tissues. Among the most promising of these in his experience were corrosive sublimate and salicylic acid.

### DISCUSSION.

DR. FOX said that his experience with corrosive sublimate in lupus was but slight and not so satisfactory as that of Dr. White. He had seen it do good, but was not able to believe that it did so by virtue of its parasiticide qualities, for the reason that it was often of service in causing the disappearance of acne tubercles. He had been surprised at hearing scarification spoken so disparagingly of in the treatment of lupus, as he was convinced that no other plan of treatment would accomplish so much in destroying the new growth, and leaving so little cicatricial tissue. He detailed the case of a young lady with lupus of the nose and cheeks, which had caused ectropion. He had treated her for eight months with scarification, removing the greater part of the disease, obtaining a brilliant result, and that without increasing the ectropion. In other cases, where loss of tissue was less to be avoided, he often used chemical means. Frequently pyrogallic acid, 10 or 20 per cent ointment had speedily removed nodules and diminished the chances of a relapse. The use of mercurial plaster afterwards he thought often did good, and he was of the opinion that a combination of the three measures he had mentioned was perhaps the best plan of treatment.

Dr. Sherwell said that at the risk of being considered too conservative or old-fogyish, he would express his profound disbelief in the theory advanced by Hyde that traumatism, or the contact with dirt from fingers or clothing, could cause lupus. He agreed with Fox as to the melting away of tubercles under mercurials. He believed in the old-fashioned view, that scrofuloderma or lupus means a condition of hereditary syphilitic degeneration.

Dr. Robinson said that he was undecided as to the connection between lupus and tuberculosis, and could not yet accept the view that the bacillus of the two diseases was the same. Although we know that the lungs are the favorite seat of the bacillus, yet lupus cases may go on for years without developing tuberculosis, although constantly inhaling bacilli. Morphological similarity is no proof of identity of nature. Lupus tissue and pulmonary nodules do not correspond, except as to the general characteristics of all infectious granulomata; their situation, mode of spreading, and time and manner of degenerating being different. He did not think that a lupus could ever turn into an epithelioma, which Dr. Hyde had stated to have occurred in two of his cases, since the former has its seat in the corium, the latter in the epidermis; as to the treatment of lupus by parasiticides, he had used mercurials a great deal in this disease for the past six years, and all that he had ever seen accomplished was the rapid breaking down of the central portions of tubercles (never of the periphery), with but temporary benefit.

Dr. Graham agreed with the last speaker that the identity of the two affections was not proved. He thought that the case cited by Dr. White, in which lupus was also present in the larynx, was proof of the different nature of the two affections; for in that the patient must have constantly inhaled bacilli, and yet no tubercle developed, although the lungs were predisposed thereto.

Dr. Tilden thought lupus a form of tuberculosis of the skin, although not all tuberculosis of that organ was lupus.

Dr. Rohé did not believe that oleate of mercury and calomel were parasiticides. He was now treating a case of lupus with lactic acid with beautiful results.

Dr. Hyde said that Dr. Taylor had suggested to him the use of bichloride of mercury and tinct. benzoin. He had used it in lupus and infecting chancre, and had found that, although it caused pain at first, this soon stopped. He thought it a very serviceable dressing. As to what Dr. Sherwell had said about the etiology of lupus, he himself thought inherited syphilis inherited syphilis and nothing else, and that it had nothing to do with any other disease. Dr. Robinson's argument against the identity of lupus and tuberculosis was, he thought, refuted by syphilis, the lesions of which, such as mucous patches and gummata, differ as much as tuberculosis and lupus.

Dr. White said that Dr. Fox's statement, that the good work of the bichloride in lupus was not due to its parasiticide action, was refuted by the fact that substances which cause ordinary inflammatory tissue to break down do not cure lupus. When the non-identity of lupus and tuberculosis was attempted to be shown by the fact that the former did not give rise to the latter, he would point to the circumstance that neither syphilis nor leprosy lesions spread to other tissues. This is a peculiarity of all bacillous diseases.

DR. TAYLOR remarked that the ointment used by Dr. White had been employed one hundred years ago, by Sedillot, for the cure of syphilis.

DR. FOX mentioned that he had recently observed the development of tuberculosis of the lungs in a patient suffering from a lupus of the nose.

DR. HARDAWAY then read a paper

### ON THE TREATMENT OF PORT-WINE MARK BY ELECTROLYSIS.

In it he stated that, in the treatment of this malady, the object was to excite sufficient inflammation to cause occlusion of the vessels. Electrolysis seemed to be the most convenient way of doing this. At first, he had used a bundle of needles, but after their use the reaction was too violent, and there was also a great tendency to keloidal development, so that he now employed only the single needle. It is important to allow a period of some weeks to elapse between the operations. The histories of three cases were given, in which this method had been employed. In two, the result was very gratifying; in the third, but little was accomplished.

### DISCUSSION.

DR. WHITE had recently used the treatment spoken of in the paper in a case of unilateral port-wine mark, and also in others. He could not state that he had produced a complete cure, but great improvement had taken place in all, and in some diseased patches complete obliterations of the vessels had resulted. He had also used the method in cases of rosaceous redness with telangiectasic new growths with marked benefit, which was often but temporary, however, the disease seeming to have a strong disposition to recur.

DR. WIGGLESWORTH thought that not enough stress had been laid upon the advantages to be derived from cutting the dilated vessels across in two places, and rubbing in a solution of persulphate of iron.

DR. HYDE had used the method recommended by Dr. Sherwell, of tattooing port-wine marks with chromic acid, with good results. When electrolysis was recommended he had used it, and in small telangiectases with good results. But his results with port-wine mark were different. He had found it best, in using this means of treatment, to insert the needle at distances of from one-quarter to one-half an inch. Not long ago a patient applied to him, stating that he was about to be married, and had something wrong with his penis. On examination, he found what he had never before seen, viz., an organ covered with a port-wine mark. It measured nine inches from root to tip, and four and a-half inches in circumference. The glans had a peculiar "peppery" appearance, and the dilatation of the vessels extended down the inner aspect of one thigh. The organ was otherwise normal in all respects except that when erect it never rose above the horizontal line.

DR. FOX remarked that the so-called "spider cancers" or simple telangiectases were usually readily amenable to treatment, but that it was different with port-wine mark. Over no other disease had he spent so much time and thought in devising an efficient plan of treatment, and in no disease had he so completely failed. He thought that the use of electrolysis was in many instances better than any other plan recommended. He had tried Dr. Sherwell's plan, that of puncturing the patch and rubbing in carbolic acid, before that gentleman had written about it. He was accustomed to pass the needle in obliquely and deeply, in the hope of striking the artery of supply. In nævus of the lip he had often entirely transfixed the part.

DR. SHERWELL said that in some port-wine stains the arterial element seemed to predominate, producing an intensely red patch. In such cases he had frequently had very bad results of treatment. He thought the best results were obtained in cases characterized by lividity of color, in which the venous element was predominant. He had since his first experience with tattooing felt less and less enthusiastic over the value of the method of treatment which he recommended, and was now somewhat tired of it. He had several times seen keloid follow the operation. He had once injected seventeen drops of carbolic acid, and two days later twelve drops into a cavernous tumor on the face of a child five months old. Severe reaction followed, the eye being entirely closed for a few days, but the child recovered entirely. A few days later he had injected twenty-three drops of the same agent into the face of a child seven months old. The practice he thought a very dangerous one, and he would not repeat it, and only did it in those two cases as a final resort.

DR. TAYLOR remarked that port-wine marks on the glans penis and the tegumentary sheath of that organ were not very uncommon.

DR. ROHÉ had seen a cirsoid aneurism of the penis.

DR. DENSLOW had recently had a case brought to him of a child three months old, with a vascular tumor on the labium mājus, covering also the lower part of the nympha. It first appeared at the age of one month, when it ulcerated over one-third of its surface. The ulcer remained stationary for two months. He applied a solution of gutta percha as a placebo, and strange to say, two days later, the entire mass had sloughed out through its entire depth. The ulcer left behind healed in three weeks. He raised the question whether the compression had had any influence in producing this result.

DR. HYDE thought not. Such ulcerations were common and often sudden, and might possibly be due to a clot in the nutrient vessel.

DR. HARDAWAY said that he believed that up to to-day electrolysis was the most agreeable and successful means of treating port-wine mark. He recommended mopping very hot water upon the part after the operation, as it notably lessened the inflammatory reaction.

DR. SHERWELL then read a paper

### ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.

The main object of the paper was to express the author's affirmative opinion of the ordinary and usual evidences of general good health in individuals suffering from the named skin-disease. It expressed the surprise he felt at the non-concurrence in this view on the part of some eminent modern dermatologists.

It gave a résumé of the European and home writers on the subject, in the effort to obtain "consensus" of opinion. He found the French authors consulted, Alibert, Rayer, Gibert, Hardy, and Bazin, in favor of the view advanced; Cazenave and Biett nearly so. German authors: Fuchs, Simon, A. Weyl, Hebra, Neumann, Kaposi, Behrend, Lesser, first three named non-committal, the others very decided in agreement. The English authors, on the contrary, theorize much on the subject, and in their writings cast about for a diathesis of some kind to explain the eruption. Some of their statements he thought ridiculous, as well as contradictory and unsatisfactory. He quoted Daniel Turner, Willan, Bateman, Jonathan Greene, Plumbe, Erasmus Wilson, Hunt, Neligan, Gaskoin, and Tilbury Fox. The latter author only by inference sustained the author's proposition.

He then gave a list of the more prominent American authors, and a condensation of their views, and spoke of, and commended the elaborated theory of the pathogenesis of psoriasis found in Dr. Piffard's work of 1876, as being plausible and possibly correct essentially. He reïterated his views, as given in a former article on pseudo-psoriasis, in reference particularly to the general primary good health of these people, antedating the syphilitic infection.

### DISCUSSION.

DR. ROBINSON expressed his belief that the physical condition of the patient had nothing whatever to do with psoriasis. He had seen the disease in chlorotic, anæmic, tubercular, as well as in healthy persons. It was ordinarily an hereditary, purely local trouble, an hyperplasia of the skin.

DR. GREENOUGH held the same opinion, but had found that a very large proportion of those suffering from psoriasis were robust.

DR. HEITZMAN thought that the simple truth of the matter was that we knew nothing whatever about the cause of the disease, and that all speculation about "the rheumic diathesis, suboxidation, and overacidity of the system" was arrant nonsense.

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### *Second Day—Morning Session.*

DR. FOX, by permission of the Association, presented a photograph and read the histories of two well-marked cases of dysidrosis or pompholyx.

The first case, for want of a better name, he classed under this heading. The patient was 29 years old, and had always perspired freely. Four years ago the eruption began on the palms of the hand and had remained ever since. At one time the soles of the feet were also affected. The skin of the hands was thick and of a dark hue, dotted with numerous epidermic elevations, of hemp-seed size. The spots had never been moist, there was no itching, and no desquamation. No fluid was obtained by puncturing the lesions.

The second case was that of a middle-aged woman, of good health. The eruption, of five years' standing, was on the face, and consisted of numerous large and small clear vesicles.

### DISCUSSION.

DR. DUHRING said that the case whose photograph was shown seemed to be a true dysidrosis, an inflammatory affection entirely distinct from pompholyx.

DR. ROBINSON said that dysidrosis consisted of an obstruction of the sweat ducts in the corium. It might last months or years, the lesions showing no tendency to grouping or spreading. There was no relation between the two diseases, dysidrosis and pompholyx. Sweat acts simply mechanically when retained in the skin, causing no inflammation. Pompholyx closely resembles pemphigus, and is a neurosis.

DR. STELWAGON had seen at least six cases similar to the one pictured in the photograph. He was unable to decide whether they were instances of dysidrosis or sudamina.

DR. ROBINSON then read a paper on

### MYCOLOGICAL STUDIES IN RINGWORM AND FAVUS.

The first portion of the paper was devoted to a consideration of the conditions favorable to the growth and development of the hyphomycetes or moulds; and the remainder to a description of the anatomical seat of the fungus in the two diseases, the changes produced in the tissues invaded, and the changes, if any, in the surrounding tissues.

He maintained that a suitable nidus from which they can obtain material for their development, together with a free supply of oxygen, moisture, etc., is necessary for their active growth. In defence of the view that a suitable nidus is necessary, and that this condition as a rule is not present in normal epidermis, he said that practically we know that every epidermis is not equally suitable for their growth, that the epidermis of children is a more favorable ground for favus and ringworm than that of adults, whilst the latter is more favorable for tinea versicolor. The epidermis of every child is also not equally favorable for the growth of favus or ringworm, neither is that of adults equally suitable for tinea versicolor. Some change in the vital energy of the tissues, consisting, as a rule, in a lowered vitality, or in some alteration of its metabolism, is necessary to enable the organisms to develop (Boyd). Practically, we see in the case of ringworm how a lowered vitality of tissue, as occurs in scrofulous or ill-nourished children, is a favorable condition for the growth and development of the fungus as compared with the disease in the robust and well nourished. In the former the disease is very difficult to remove, and it may be absolutely necessary, in order to be successful, to combine internal medication with local means.

With reference to the anatomical seat of the fungus in favus, he never found it to pass into the rete, corium, external root-sheath of the hair or hair-bulb, unless these parts had become structurally changed from pressure or inflammation. In these observations he is in accord with Unna, and against Malassez, Hoggan, etc., who maintain that the fungus penetrates, grows downward through the rete into the corium. It may be present in these situations, but only when it replaces the tissues previously destroyed; it does not grow in the normal, succulent, living tissue. The depressed centre of the favus scutulum owes its formation in great part, no doubt, to the anatomical relations of the upper epidermis cells to the cuticula of the hair—their close connection and difficulty of elevation by the growing favus mass beneath, as compared with the surrounding epidermis, as already described by Kaposi; but the author believed that another important factor was the structure of the cup itself. The peripheral portion consists of a dense collection of mycelium, imbedded in a granular débris which also contains many micrococci; the central portion, on the other hand, consists almost exclusively of spores which are not very densely packed, hence the peripheral part of the favus cup is much firmer and more resistant to external pressure than the central part and does not so readily sink in.

The fungus elements act locally and mechanically upon the tissues, the epithelial cells and layers are more or less separated from each other, the amount depending upon the amount and situation of fungus present. The rete cells are compressed to a greater or less extent, as also the granular and stratum lucidum layers. In advanced stages of the disease, all these structures undergo degenerative changes and become more or less destroyed; first the corneous layer and then the other layers in succession, either in consequence of pressure from the favus elements or from inflammatory changes proceeding from the corium.

The changes in the hair and hair-follicle area are similar to those in the epidermis just described. The hair-shaft is invaded directly from the fungus lying between the inner sheath and the cuticula, or indirectly by gaining entrance through the cuticula at some point and then passing upward and downward along the shaft, separating the elements. The hair-shaft is also changed in nutrition, even when not invaded by the fungus, and in consequence shows a longitudinal striation caused by air between the fibres—an appearance greatly resembling that caused by mycelium. This appearance, first described by Aubert, is very characteristic of favus, and is not met with, the author believes, in tinea trichophytina. Strangely, this author denies the invasion of the hair-shaft.

The changes which occur in the cutis are those of inflammation and retention. The former varies in intensity from the slightest grade to complete destruction of the epidermis and upper part of the corium, or even of its deeper part and substitution by cicatricial tissue. The changes produced by retention are cystic degeneration of the sebaceous and sweat ducts. The rarity with which sebaceous glands are found in cases of favus is noteworthy. The author believes they are very early destroyed by the inflammatory process.

In tinea trichophytina the fungus was found in the corneous layer, in the rete, and even in the corium, as well as in the hair and its sheath. In accordance with the view of several English authors, the fungus was found also upon the free surface, as well as between the epithelial cells. In tinea trichophytina capitis the greatest number of fungus elements was found in the hair and the funnel-shaped part of the hair follicle. The cuticula is frequently not invaded in the early stages and sometimes not until the hair is more or less destroyed. The peripheral part of the shaft, excluding the cuticula, is also attacked by preference to the medullary part. The fungus also extends in the hair much further above the free surface than it does in favus.

There may be no appreciable inflammatory changes or they may be marked. In the former cases the clinical symptoms may resemble very closely those of alopecia areata, and a microscopical examination of the *hairs* be necessary to decide as to the nature of the disease. In tinea trichophytina barbæ the same conditions are present as in the scalp, but the inflammatory changes are always decided when the follicle is invaded by the fungus. Whether the fungus penetrates the corium or not could not be decided, owing to the inflammatory changes in the corium in the sections examined, but it is more than probable it does.

In tinea trichophytina corporis (tinea circinata) the fungus was found in the epidermis and even in the corium, in small numbers. But few were found in the hair shaft, although they may be abundant in the mouth of the follicle. The fungus penetrates the corneous layer and may spread by travelling along the free surface or between the corneous layers. Having found a suitable nidus, they grow and multiply and *produce the slight elevation* of the skin observed in ringworm. Unless the inflammation is marked, the lesions of ringworm, the slightly elevated rings, or papules, or indications of vesicles are formed of fungus elements and changed epithelial cells. The changes in the corium may be slight, or there may be sufficient inflammation with exudation to produce vesicles or pustules.

### DISCUSSION.

DR. WHITE could not agree with the statement of the author that the disease, ringworm of scalp, was more liable to affect ill-nourished scrofulous children. In his experience, the fungus of this disease exhibited no choice in the selection of its host, he having found it to affect its subjects independently of individuality, it affecting all if given an opportunity, well or sick. Ringworm of the beard, in the vast majority of instances, occurs in perfectly healthy men.

So far as cure of the malady was concerned, he had never seen the necessity of internal treatment, which he would employ only for the reduction of secondary phenomena, but not with a view to the destruction of the fungus.

He was astonished at the stress so often laid upon the so-called vesicular nature of the eruption. He had never seen any vesicles in it, and could never understand why the disease should have been called a herpes.

DR. SHERWELL, speaking of the treatment, said that saturating the scalp with oil he considered a parasiticide measure, it acting by depriving the fungus of air.

DR. PIFFARD agreed with Dr. Robinson as to the systemic conditions usually found in those suffering from ringworm. He considered kerion a disease of the scrofulous, and had never seen it in the robust. He did not consider it a third stage of ringworm, as Dr. White had called it.

DR. DUHRING said that, as to the condition of the soil chosen by ringworm, he had always held that a peculiar condition of the surface was necessary for the propagation of the growth. He did not think that the subjects must necessarily be below par, but had found that they usually were. He did not believe that all persons were subject to ringworm. Some peculiar (unknown) condition of the epidermis must exist to render them liable to it. Robust children get well more rapidly than delicate ones. He had seen true vesicles in ringworm of the general surface.

DR. HEITZMAN agreed with Dr. White that the disease affected the robust as well as the delicate. He had seen strong healthy men covered with ringworm from head to foot. No internal treatment was needed to cure the disease, and he was surprised to hear gentlemen still talking about the system being at fault in the disease. In his opinion there was no basis for any such belief.

DR. DENSLOW had recently seen a large number of cases of the disease occurring on lumbermen of the Northwest, who were usually men of iron. They always recovered without internal treatment.

DR. PIFFARD remarked that chromophytosis occurred twice as often in syphilitic subjects as in non-syphilitic, and he had repeatedly seen it get well under antisyphilitic treatment without local treatment. Whether or not this was the result of the elimination of mercury by the skin he was unable to say. Mosquitoes also showed a preference for certain persons.

DR. HARDAWAY said that, although he had a preconceived notion that ringworm attacked only delicate persons, he had never been able to prove it by observation.

DR. ROBINSON said that, as external conditions made a difference as to development of the fungus, so also did the soil on which it grew make a difference. The disease was much more frequent in children than in adults, and in hospitals some children get it while others do not, and some were much more easily curable than others. It was a well-known fact that the bacillus anthracis could be successfully inoculated in young dogs, but not in old ones. Ringworm untreated gets well at puberty, on account of the fact that the tissues change.

DR. HEITZMAN then read a paper on

### THE STRUCTURE OF THE DERMA AND THE DEVELOPMENT OF ELASTIC TISSUE IN IT, WITH DEMONSTRATIONS.

In it he stated that the derma is made up of interlacing bundles of so-called fibrous connective tissue, which are comparatively coarse in the middle and lower portions of the derma, and delicate in the papillary layer. The bundles look striated, owing to the presence of dense spindles, representing the glue-yielding basis substance proper, being united with each other by a less dense, so-called cement substance. Real fibres appear only after teasing or after application of chemical reagents. Between the bundles lie the protoplasmic cords, freely supplied with nuclei, and, according to the general spindle-shape of the bundles, branching and connecting everywhere. Isolated cells or connective-tissue corpuscles do not exist in the derma, nor in any other variety of fibrous connective tissue, such as tendon, aponeuroses, ligaments, etc. Starting from the protoplasmic cords, delicate offshoots pass into the bundles and freely connect with an extremely delicate reticulum of living matter which traverses the basis substance to such an extent that only the meshes of the reticulum contain the glue-yielding basis substance. The delicate interstices between the spindles or fibres, the cement substance, is again traversed by minute spokes of living-matter. Thus the whole basis substance is endowed with properties of life, and in inflammation the formation of inflammatory or eventually pus-corpuscles, though starting from the protoplasmic cords, goes on from the latter as well as from the bundles.

With advancing age, the interstices between the bundles, filled with protoplasm, decrease in size, whereas the volume of the bundles increases. The interstices at length become reduced to narrow slits, and at the edges of the bundles, where the contact between them is narrowest, a very dense elastic basis substance forms, assuming the shape of elastic fibres. The branching of these fibres becomes intelligible only by assuming a direct transformation of the protoplasm into elastic substance along the edges of the bundles. In some benign tumors of the skin, such as fibrous papilloma, etc., the formation of elastic tissue goes on in a rather premature and rapid manner. All the three varieties of basis substance of the derma, the glue-yielding, the cement, and the elastic substance, are direct products of protoplasm, and all of them are possessed of properties of life.

DR. HARDAWAY read a paper on

### MULTIPLE MYOMATA OF THE SKIN—ILLUSTRATED.

### DISCUSSION.

DR. DUHRING said that the form of the lesions resembled a case of his own which had been alluded to in the paper. He thought that clinically it was very difficult and even impossible to make a diagnosis of the true nature of the affection. In his own case (which was a true neuroma), the pain was intense on slight, but relieved by firm pressure.

DR. HEITZMAN said that the specimen under the microscope showed that the derma was almost entirely transformed into myomatous tissue. He has seen only one specimen of the kind in his laboratory in ten years. He believed that the pain of which the patient complained was not due to a new-formation of nerves, but to the pressure of the growths upon already existing nerves. The specimen shows that no new-formation of nerves is necessary in order that a tumor may be painful. A myxoma, myoma, or a chondroma may be painful.

DR. MORISON next read a description of

### A CASE OF TYLOSIS OF THE HANDS.

A negro, aged 32 years, had both hands much affected with this disease. He was a fireman on a steamer, and had been working as such for ten years. The constant rubbing of the hands upon the handle of the shovel had caused callosities and subsequently ulcerations. On the left hand the ulcerations were followed by loss of tissue and bone, so that it was very much deformed. The third phalanx of two fingers was entirely gone, and the other fingers were in a state of disease which showed their ultimate demolition. The thumb of the same hand had a patch of ulceration upon its inside surface, which in a few weeks exposed the first joint, the bones becoming necrosed. The ulcerations started first as callosities. There was absolutely no pain, nor had there ever been any. The man picked out pieces of bone himself and threw them away. He had no history of syphilis, was muscular, healthy, and without any disease anywhere else on the body. No treatment, excepting rest, was advised; but the patient, as long as he suffered no pain, was not willing to give up his lucrative occupation.

Plates were shown illustrating the condition of the hands.

### DISCUSSION.

DR. WHITE said that the result of the disease was so extraordinary that he was strongly inclined to believe that there was some antecedent change in the system of the patient to cause the necrosis of the bones of the fingers.

DR. TILDEN thought that the disease in this patient bore a strong resemblance to the "mal perforant du pied" of the French. He also said that the case reminded him of lepra mutilans.

DR. DUHRING expressed the opinion that there must have been some deep-seated nervous change in the system of the patient, such as occurs in perforating ulcer. He did not believe that simple local irritation could excite such destructive changes.

Dr. Morison said that he had been unable to find any evidence of disease of nerves in the case, and that the local irritation was the cause of the trouble was shown by the circumstance that the left hand which ran up and down the handle of the shovel used in the man's occupation was much more severely affected than the right, which simply grasped the handle of the instrument.

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*Evening Session—Second Day.*

Dr. Duhring read a paper entitled

## THE RELATION OF HERPES GESTATIONIS AND CERTAIN OTHER FORMS OF DISEASE TO DERMATITIS HERPETIFORMIS.

Attention was briefly directed to the previous article of the reader on dermatitis herpetiformis, and to a paper showing its identity with the impetigo herpetiformis of Hebra; also to a preliminary note on the relation of this disease to herpes gestationis and other similar forms of cutaneous disease, read before the Association at the last meeting.

The object of the present communication was to prove the identity of so-called herpes gestationis with the vesicular variety of dermatitis herpetiformis, and to show that the term herpes gestationis is a misnomer, the affection being found in men as well as in women. Secondly, that certain other so-called forms of herpes, such as "herpes pemphigoides," "herpes vegetans," "herpes pyæmicus," etc., as well as certain cases regarded by the reporters as "peculiar forms of pemphigus," must be viewed as examples of this disease; and, finally, that instances of the same affection are also met with in literature under the title of hydroa, and under divers other captions. Numerous cases from English, French, and German literature were cited. The paper of Dr. Duhring was stated to be looked upon as supplementary to the preliminary notes referred to, and embodied the results of considerable research into literature. If the views put forth proved to be correct, a great deal had been gained for dermatology in bringing these peculiar forms of disease together.

### DISCUSSION.

Dr. White remarked that since the last meeting of the Association he had seen five cases of dermatitis herpetiformis, two of which he had treated. The more he had seen of the disease, the more he thought the title given it by Dr. Duhring a misnomer. He thought it should be called dermatitis multiformis, as he had found that the herpetic element was only exceptionally present, being entirely absent in some cases. He had never seen a case of the disease which he would have been apt to confound with herpes, though he had seen some which he might have taken for eczema or pemphigus. The vesicles, in his experience, always failed to present the tendency to grouping so characteristic of herpes.

DR. ROBINSON held the same view as the last speaker. He had seen five or six cases of the disease. He thought the name hydroa a sufficiently comprehensive one, and not misleading, as long as we know no more of the affection than at present. He thought the inflammatory changes met with were secondary to some internal derangement.

DR. HYDE thought the term herpetiform preferable to the others which had been suggested, since tradition favored it, as shown in the well-known name impetigo herpetiformis. Although he fully recognized the multiform character of the lesions, yet, in the cases he had seen, there was an unmistakable suggestion of herpes.

DR. FOX exhibited a photograph of a case which might be mistaken for herpetiform dermatitis, although it was a well-marked case of multiform erythema. He, too, did not like the name given the disease by Dr. Duhring. In his case there were vesicular and bullous lesions and typical patches of herpes iris, and in one place it showed an annular bulla, made up of a circle of vesicles which had coalesced.

DR. DUHRING could not agree with the other speakers in their objections to the use of the term "herpetiform." This characteristic was present in a more or less marked degree in all the cases, and the term was, therefore, both appropriate and expressive. Hebra recognized the herpetiform nature of his cases, and a thorough search of the literature of the subject had taught him that almost all writers on the subject did likewise. He had used the term multiform dermatitis to distinguish one variety of the affection, and that a very important one. The adjective did not, however, seem to him sufficiently expressive. He did not consider the disease a rare one. He thought that we stood on the threshold of our knowledge of the disease, and he himself was constantly learning something new about it. It was an immense process, capable of indefinite elaboration, which will be done as time goes on. Cases varied greatly as they presented themselves, as would naturally be expected in so elaborate a process as the affection represented.

DR. TILDEN then read a paper on

## "MYCOSIS FONGOÏDE."

It described the case of a man, twenty-eight years of age, who, having been in good health until his twenty-fifth year, was then, for the first time, aware of the appearance upon his elbows of several small red and desquamating spots which were attended with pruritus, affecting principally the outer sides of the arms. There were no further manifestations of cutaneous disease for several months, at the end of which time there appeared irregularly distributed upon the face, abdomen, and arms, erythematous spots and patches of various sizes and individually of a fugitive nature, accompanied by pruritus, which was the only subjective symptom of which the patient complained. According to his statement, these cutaneous lesions always retained their dry and scaly character, and were never accompanied by anything like the formation of vesicles.

With temporary variations in severity, these changes in the skin continued for about a year and a half, attended with pruritus, but unaccompanied by any change in the previous good health of the patient. At the end of this time, and for the first time, there appeared several small, red cutaneous nodules upon the left cheek and throat. Some of these nodules spontaneously disappeared, and no others showed themselves, when there appeared upon the right thigh a small papule which slowly increased in size until it formed a tumor the size of an orange, the upper surface of which was deprived of epidermis. From the pathological tissue thus exposed there exuded a thin, reddish fluid, which dried to a thin crust. The appearance of this papule was followed during the succeeding year of the disease by the development in many parts of the body, more particularly the axillæ, groins, neck, and scalp, of similar papules, many of which had developed into tubercles the size of a filbert, and several into tumors as large as or larger than a hen's egg. These lesions were at first of moderately firm consistence, and covered with smooth, pale-red epidermis, being circumscribed and rounded elevations. Under conditions of fusion and coalition of these nodules, were formed irregularly outlined, uneven, and sometimes fissured, infiltrated patches of a darker, more brownish, or bluish-red color than the original and isolated lesions, and covered for the most part with epidermis, being only here and there excoriated and oozing. Several of the larger tumors reached a stage in their evolution at which began a sluggish involution or retrograde change, manifested by the disappearance of the epidermis which covered them, thus representing the typical moist fungus excrescences of mycosis fongoïde.

In spite of this superficial erosion, the tumors affected by it preserved their size and shape for a long time. The excoriated tumors were firm in consistence, but several, which were still covered with epidermis, more particularly those upon the head, were so soft as to suggest fluid or semi-fluid contents. There were in none of these lesions any evidence of the formation of pus, or any deeply destructive ulceration. There was severe and general pruritus, but the general health of the patient was fair, the chief subjective symptoms, besides the itching, being a feeling of weakness and shortness of breath upon exertion. There was evident anæmia, and the heart presented a systolic murmur, but physical examination failed to detect anything out of the way, except indolent and painless enlargement of many of the accessible lymphatic glands.

The patient remained under observation for three months, during which time there took place development of fresh papules from previously existing erythematous spots. The last time he was seen, one of the largest tumors had entirely disappeared, and its original site was covered with epidermis, while the largest tumor of all had diminished in size by nearly one-third, without the manifestation of any quickly destructive ulceration. During the last four months the patient was not seen, but his death about three years and eight months after the beginning of the disease became indirectly known to Dr. Tilden. Two of the small nodules were excised and given to Dr. Gannett, pathologist to the Boston City Hospital, for examination, whose report showed them to consist of the new formation of cytogenous or lymphoid tissue in the corium, characterized by the presence of a fine network of connective-tissue fibres, anastomosing to form spaces of nearly circular shape, which contained round cells resembling leucocytes in appearance, the presence of which network in the new growths of mycosis fongoïde was originally described by Ranvier.

### DISCUSSION.

DR. WHITE stated that he saw the patient towards the end of his life, and had observed the same wonderful changes that had been described in the growths, many of them gradually disappearing. During the last four or five months of his life, the patient had been given arsenic, under the supposition that the disease might be sarcoma. (Arsenic had been found to render great service in two cases of this disease; one reported by Köbner, and one which occurred in Boston.) Dr. Tilden's patient improved decidedly under the use of this drug. His death was due to a sudden attack of diarrhœa. He (Dr. W.) had no opinion to offer as to the nature of the disease. He saw no reason why multiple sarcoma could not terminate in this affection. No autopsy was made in the case.

DR. ROHÉ had seen a case similar to the one described. He then thought it sarcoma.

DR. FOX had seen one or two similar cases in New York. If he had one to treat, he would try the effects of chaulmoogra oil.

DR. HARDAWAY alluded to a case of pigmented sarcoma which he had reported four or five years ago. The man was still alive.

DR. WHITE said that he had seen a case which had been regarded as one of "remarkable syphilis," and had found it to be an instance of the affection under discussion.

DR. DUHRING spoke of a case of the disease which he had described. In it lesions of the wall of the bladder were found after death. At present he would consider the disease as closely allied to sarcoma. He thought that the differences between well-recognized forms of sarcoma were as great as between sarcoma and mycosis fongoïde.

DR. HEITZMAN said that the histologist who had examined the specimen had described a myxo-sarcoma, and he was unable to understand how he had reached the conclusion that the disease was not a sarcoma. The clinical history, and the description given of the case, fitted myxo-sarcoma exactly, and he saw no valid reason for the use of the term "mycosis." He thought it a plain case of sarcoma.

DR. SHERWELL spoke of a case of melano-sarcoma, where there were many pedunculated and flattened tumors on the body and leg. The patient was vigorously treated with arsenic and mercurials, and is now almost free from the disease.

DR. HARDAWAY asked Dr. Heitzman if microscopical differences would account for differences in the clinical course of the various sarcomata?

Dr. Heitzman said that since Billroth had described alveolar sarcoma, it had been recognized as a less malignant affection than myxo- or fibro-sarcoma. Billroth had, it was true, afterwards withdrawn hie statement that it was a form of sarcoma and had called it cancer, but he H.) was still of the opinion that it was a variety of sarcoma.

Dr. Tilden said that patients with this disease generally die of exhaustion, often with diarrhœa, but presenting no internal lesions to account for death. He had chosen the name mycosis fongoïde because he knew no better one. He was confident that it was neither sarcoma nor lymphoma. Its clinical course was not at all like that of ordinary multiple sarcoma, as described in writings on the subject, particularly as regarded the rapid spontaneous involution of many of the lesions.

Dr. White said that sarcomata might also disappear under arsenic by hundreds, as he had seen in one case, in which as many as two hundred tumors thus disappeared, staying away two years.

After studying the microscopical specimens exhibited by Dr. Tilden, Dr. Heitzman pronounced the case to be, not one of myxo-sarcoma, as he had supposed it to be, but of lympho-sarcoma.

Dr. Denslow then read a paper on

## THE TREATMENT OF ACNE BY THE USE OF SOUNDS IN THE URETHRA.

He prefaced his remarks by a brief review of the cases of contracted meatus reported by Dr. Otis. He then gave an account of a number of cases coming under his observation, in which there were reflex conditions associated with such conditions of the urethra as contracted meatus, stricture, and excessive sensitiveness of the prostatic urethra. In these cases removal of the urethral trouble produced an alleviation or cure of the affection to which attention had been directed. He also reported four cases in which the same treatment was followed by marked improvement or cure of the skin disease (acne).

### DISCUSSION.

Dr. Hyde desired to call attention to a fact bearing upon the subject discussed in the paper, viz., that many patients with urethral troubles were in the habit of taking internal remedies without the knowledge of the physician, which might, he thought, often excite acne medicamentosa, or they might be taking drugs secretly for sexual hypochondriasis, under the belief that they had blood-poisoning. He would ask Dr. Denslow, in treating cases of acne with sounds in the future, to ascertain how many of the patients had been taking drugs, and how many stopped using them at about the time the acne improved.

Dr. Denslow said that in none of the patients whose cases he reported was the acne due to drugs, and none of them were in the habit of masturbating. He had no theory of the etiology of acne to advance, but had in his paper simply reported a small number of facts which he had observed since January.

*Third Day.*

DR. HEITZMAN made some

### REMARKS ON ELECTROLYSIS AND OTHER PRACTICAL TOPICS.

He recommended for the electrolytic destruction of the papillæ of hairs, in cases of superfluous hairs on ladies' faces, the Leclanché battery consisting of six large cells (each over 12″ in height) united to one circuit. The advantages of this battery are: it is painless, even the most sensitive person can stand it without inconvenience; the reaction following the introduction of the needle is slight, passing away in a few hours; no pustule and no scar would follow; it is in steady action for at least half a year. Perhaps the failures to destroy the roots of hairs occur more frequently than with the more powerful chromic acid battery. In some cases it happens that a number of downy hairs, after the removal of large hairs, grow up to a large size very quickly, which, perhaps, is due to the carrying of cast-off nutritive material to the fine hairs.

He exhibited a needle-holder, manufactured by Leiter, of Vienna, offering the advantage that the depth to which the needle is introduced could be accurately measured.

Stronger and painful currents had in his hands proved highly satisfactory for the destruction of dilated blood-vessels in the face, the last remnants of rosacea. Less favorable results were obtained in the destruction of flat angioma-spots, so-called port-wine marks. Some cases could be reduced in the tint of their color, others made to disappear, but sometimes after a few months all improvement disappears, and the angioma looks as bad as ever. Trials with the alcoholic solution of sodium æthyl proved that this caustic is in no way superior to nitric acid, and that it is prone to produce scars if brought to bear upon the skin for any length of time, the same as is nitric acid. He described a case of a pale spot on the left cheek of a lady over forty, which was two inches in diameter, dark purple-red and sharply circumscribed, evidently caused by a vasomotor (sympathetic) paralysis. In this case even strong electrolytic currents proved to be of no avail.

The speaker then summed up the results of two hundred cases of falling of the hairs caused by seborrhœa, where he applied the tar-pomatum recommended by him in 1876 (10 to 20 p. c. ol. rusci crud. in vaseline and paraffin, the smell of the tar being nearly destroyed by means of fragrant oils). 12 p. c. of these cases proved to be failures: in a double percentage, the improvement was but temporary; in a limited number the favorable result was lasting. He considers this pomatum a valuable remedy, always to be tried in suitable cases, alternately with sulphur and white precipitate ointments.

He recommended for the removal of freckles an ointment, the formula of which was given him by Prof. Wertheim in Vienna. The ointment is hydrarg. ammon. muriat., grams 3.75; magister. bismuth, 3.5; unguent. glycerini, 30.; to be applied only every other night.

### DISCUSSION.

DR. WHITE said that he thought the fact that Dr. Heitzman obtained no better results from electrolysis was owing to the circumstance that his current was not strong enough, not causing pain. He himself did not anticipate that more than one hair in ten would return; on the upper lip, not more than one in twenty; whereas Dr. H. expected three or four in the same number to grow again. He himself always produced some pain in operating. He was accustomed to use a chloride of silver battery, which had the advantage of requiring to be filled only once a year. It contained twelve cells, of which he used from six to ten, rarely the whole number. He was accustomed to tell patients that on the chin and neck only one hair in four could be permanently destroyed. He thought the needle-holder exhibited by Dr. Heitzman too short by half, and preferred one the length and size of an unshortened lead-pencil. He did not consider the shoulder or guard necessary, believing that the educated touch was sufficient to regulate the depth of penetration. He used on all parts of the face, except the upper lip, the common steel broach of very small size. Such a needle could be easily bent, and was almost indestructible. He had used one for thirteen months one hour daily; on the upper lip he preferred to use the irido-platinum needle, which is made extremely fine. He thought the cosmetic effect was in proportion to the smallness of the needle used.

As regarded the treatment of seborrhœa of the scalp, he always gave a favorable prognosis in the case of females, an unfavorable one to males. He, too, liked the effects of tar, but thought the odor and nastiness of the drug objectionable. He now used salicylic acid and sulphur, as recommended by Unna, with very good results.

DR. HYDE, alluding to the statement of Dr. Heitzman, that the nutritive material destined for the large thick hairs was diverted to the downy hairs after the removal of the former, said that in the case of a patient with long black hairs on the chin, if the operation is done, the hairs return and the operation is repeated. Thus an excessive hyperæmia is excited, leading often to urticaria, papulation, or pustulation, and conditions favorable to the growth of hairs, the down growing into coarse dark hairs.

He thought that great injustice had been done the American operation in the last volume of Ziemssen's Cyclopædia, in which it was stated that fifty per cent of the hairs returned after removal.

He indorsed what Dr. White had said about the uselessness of a guard on the needle-holder, and preferred the steel broach or irido-platinum needle to anything he had ever seen for the removal of hairs. He had used the rectified oleum rusci and thought highly of it, and was surprised to learn that Dr. Heitzman thought so little of it.

DR. ROHÉ used the McIntosh, a bichromate battery with small cells. He rarely used more than ten or twelve. He had found that the Leclanché cells soon wore out, and being open circuit cells they had to stand a long time to recover.

Dr. Fox said that any battery producing a good electro-motive force was good for electrolysis, and that keeping the connections bright and clean was far more important than the choice of any particular battery. In the treatment of nævi, he was in the habit of applying nitric acid in the form of small dots a quarter to a half inch apart. He also liked the effect of the passage of a galvano-cautery instrument quickly over the skin. This caused contraction of the vessels and left no scars.

He thought that, in electrolysis for the removal of hairs, if the needle were carefully inserted and no traction made, the hair would not return. In his experience about one per cent returned. He thought that in some exceptional cases there was a tendency to the constant growth of downy hairs. In other cases, where this tendency is no longer present, the result of treatment is better. He did not accept Dr. Heitzman's theory that the extra nutrition left after removal of large hairs went to the downy ones, nor did he think that the hyperæmia produced by the operation stimulated the growth of the remaining hairs.

He thought that the general results of the operation were good, and spoke of one case in which he removed eight thousand hairs, the face being now practically free from hair and had been for three years. The marks left by the operation were exceedingly slight. The choice of holder and needle was a matter solely of personal preference. He was surprised at the success obtained by Dr. Heitzman from the use of the ointment whose formula he had given, and would expect the freckles to reappear after a time.

Dr. Robinson had used a similar salve for years, and had found that it had a temporary good effect, making the skin clear and rendering the pigment less visible. He thought that chronic hyperæmia did increase the growth of hair, as shown by the fact that over fractures, and sometimes after eczema, the hairs grow more abundantly than on other parts. He used electrolysis only in those cases where there were a few large hairs, not those in which they were abundant and of all kinds.

Dr. White thought that after the operation the lanugo hairs simply grew on but were not stimulated by the operation, simply becoming more prominent because the large hairs had been removed.

Dr. Hardaway said that he had been doing this operation for the past eight or ten years and thought very highly of it. He was glad to hear that Dr. Heitzman's views of it had changed, and that he now admitted that it was a true electrolysis and not galvano-cautery.

He liked to use a heavy holder, so that the needle would pass in by its own weight, thus avoiding perforation of the follicle-wall. The irido-platinum needle, which was first suggested by Piffard, had the advantage of bending like a bougie and following the course of the canal. He used the MacIntosh battery, and found it a very good one. He thought that much less scarring would follow the operation if the needle were coated up to a certain point so as to make the destruction subcutaneous.

He often told patients that the downy hairs would become visible after the large ones were removed. He knew that the operation was often a complete and radical success, the hairs never returning. His first case was that of a bearded woman, whom he treated about twelve years ago. She is now practically relieved from her disfigurement, although many scars were present he would admit.

He thought a point of great importance was to use hot water three or four times a day after the operation, and another was to make the operations far apart, at least once a week, to allow the skin time to recuperate. He had tried cocaine to relieve the pain, but had never seen it do any good in this way. He thought it was important to leave the hairs in situ until the electrolytic action was complete, and then to pull very cautiously. The expert touch would of course tell when the follicle was reached, but he had often noticed that the sebum would froth out before the connection was made, showing that the follicle was entered.

He regarded the use of electrolysis as a valuable means of getting rid of freckles, particularly the large dark ones, dotting them with a stiff needle. The best drug for their cure was in his opinion sulphur.

DR. ROHÉ had noticed the frothing when the needle entered the follicle, and had found the reason to be an accidental defective connection prematurely made.

DR. HEITZMAN said that in his experience one hair in four will return on the upper lip and neck, and one in ten on the chin. He did not think that personal skill had much to do with the success or failure of the operation. Hairs were often spiral or corkscrew-like, and the papillæ could not of course be reached.

He thought there was only one test for good oleum rusci crudum, and that was to mix the specimen with three parts of alcohol, put it on the finger, and if it dried in a few minutes it was good. The rectified oil dries more slowly and leaves a black mark. He had found that the remedy only did good in baldness, when seborrhœa was the cause of the trouble.

DR. TAYLOR then read a paper

## ON SYPHILITIC REINFECTION.

He first referred to the literature of the subject, and gave a brief review of the authentic cases on record, giving the names of the reporters. The number of cases previously reported is between thirty and forty. To these he added the histories of three more. A fourth case has been observed by him, but, as the complete history was not prepared, it was not given.

### DISCUSSION.

DR. HYDE thanked Dr. Taylor for so valuable a contribution to our knowledge of this rare occurrence. He himself had seen only two cases of reinfection, many others which at first were thought to be of this nature proving to be simply relapsing indurations.

DR. STELWAGON then read a paper entitled:

## "OBSERVATIONS ON THE OLEATES IN SKIN DISEASE."

In it he regretted the lack of reliable observation concerning the action of the oleate preparations. His personal experience, somewhat extended, had placed in question their therapeutical importance. The oleate of mercury, oleate of lead, oleate of zinc, and oleate of bismuth in his judgment were the only oleates that had proven of service. The oleate of mercury in inunction treatment of syphilis is not comparable to the blue ointment; in fact, the ready absorbability of the former mercurial is questioned, the writer's clinical observation in this respect being in accord with the experiments made by Dr. Brubaker, of Philadelphia, to determine the same question. The oleate of mercury, in the form of a twenty-five per cent ointment, is especially valuable in the treatment of ringworm of the scalp, and the same, or a somewhat weaker ointment equally efficacious in tinea sycosis. He had found oleate of copper of very little value. The oleate of lead melted with an equal part or more, dependent upon the season, of lard, forms a soothing and astringent ointment, an efficient substitute for diachylon ointment. Oleate of zinc, in ointment, compared to oxide of zinc, is more astringent and stimulating, but more apt to disagree as a dusting powder, the conclusion reached was that it is impracticable, as in the presence of heat and moisture (that of the skin sufficient) it becomes sticky. The oleate of bismuth, with lard, or alone, forms a soothing ointment.

In view of the difficulty of securing good preparations, the disagreeable oleic acid odor, the costliness, the frequency of unlooked-for irritating effects and other disadvantages, the writer concluded that the oleate of mercury is the only preparation which promises to hold a permanent value, and even that recedes from its importance of a few years ago.

In regard to the chemistry and preparation of the various oleates, both as to their manufacture by the direct combination of the acid with the base and by double decomposition, almost, if not entirely, as much can be found in the English translation of Gmelin's "Handbook of Chemistry," published in 1866, as in the writings of the past several years.

### DISCUSSION.

DR. TILDEN thought the oleates of but little value, and that the oleate of mercury was not so good as blue ointment.

DR. WIGGLESWORTH believed that the only value of the oleate of mercury was as a parasiticide.

DR. DUHRING coincided with the conclusions of the reader of the paper. A few years ago, he was treating forty or fifty cases of ringworm, and used large quantities of a pure preparation of the oleate of copper, gave it a faithful test, but found it had no influence on the disease, which continued to spread. There were no cases of recent ringworm among the number. The drug was also very unpleasant to apply to the skin.

DR. HEITZMAN had found that the oleate of copper did good only in the acute stage of ringworm.

DR. FOX said that in his experience vaseline was much more readily absorbed by the skin than oleates or animal oils. Vaseline he thought the most soothing of all applications, and he had made careful observations.

**Dr. Sherwell** had not used oleate of copper. He had used the five-per-cent oleate of mercury, which was a very unstable compound. This he had found to do good in even a very weak mixture. As regarded vaseline, he detested it, and thought it almost an irritant. He much preferred cold cream for soothing purposes.

**Dr. Taylor** also regarded vaseline as an irritant. The unperfumed white vaseline was less so than the brown, but cosmoline he thought better than either.

**Dr. White** had tried oleate of copper several times as a parasiticide, but without success.

**Dr. Hardaway** had used oleates, but had now discarded them entirely. He had had some success with oleate of copper as a parasiticide.

**Dr. Denslow** then read a paper on

## A CASE OF SYPHILITIC APHASIA AND PARAPLEGIA FOLLOWED BY DEATH, WITH AN ACCOUNT OF THE AUTOPSY.

About two months before the patient, a middle-aged man, was first seen, he was attacked by a severe headache, much worse at night. He was found to have alopecia, and a papular eruption most marked about the face and scalp. He had had a sore on the penis a few months before. He was then given iodide of potassium in increasing doses, up to half an ounce daily, and croton chloral. At the end of two weeks he was free from pain. The pain returned two weeks later, and he was again ordered large doses of iodide. By mistake he took drachm doses every two hours, which upset his stomach, but failed to relieve the pain.

When first seen by Dr. Denslow, he was unable to speak or to comprehend questions, and was paraplegic. He sank rapidly and soon died.

On autopsy, the dura mater along the superior longitudinal sinus was found to be thickened and adherent to the pia mater. On the external surface of the pia there were numerous small gummata or cheesy-like masses about the size of millet seeds; these were situated mostly along the right border of the superior longitudinal sinus, extending down to the upper extremity of the fissure of Sylvius. Both the dura and the pia mater showed signs of simple acute inflammatory changes in the regions covered by the masses. The ventricles and interior of the brain showed no pathological changes.

## REPORT OF THE COMMITTEE ON STATISTICS, AMERICAN DERMATOLOGICAL ASSOCIATION,

*For the Year Ending June 30th,* 1885.

### TABLE I.

| Districts. | Name. | Private Practice. | Public Practice. | Total. |
|---|---|---|---|---|
| 1 | Boston | 872 | 3182 | 4054 |
| 2 | New York | 705 | 2891 | 3596 |
| 3 | Philadelphia | .... | 1662 | 1662 |
| 4 | Chicago | 1608 | 1067 | 2675 |
| 5 | Baltimore | 110 | 1022 | 1132 |
| 6 | St. Louis | 279 | 609 | 888 |
| 7 | Canada ........ ..............Returns lost by tr | ansmis | sion in | mails. |
| | Total | | | 14,007 |

### TABLE II.

*Showing the Returns from the respective Districts.*

| | Private Practice. | Public Practice. | Total. | Boston. | New York. | Philadelph. | Baltimore. | Chicago. | St. Louis. | Canada. |
|---|---|---|---|---|---|---|---|---|---|---|
| **Class I. Disorders of the Glands.** | | | | | | | | | | |
| 1. OF THE SWEAT GLANDS | | | | | | | | | | |
| Hyperidrosis | 22 | 19 | 41 | 9 | 11 | 8 | 1 | 9 | 3 | .. |
| Sudamen | 4 | 33 | 37 | 3 | 19 | 5 | 1 | 9 | .. | .. |
| Anidrosis | 1 | .. | 1 | .. | 1 | .. | .. | .. | .. | .. |
| Bromidrosis | 9 | 7 | 16 | 2 | 8 | 3 | .. | 3 | .. | .. |
| Chromidrosis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Uridrosis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 2. OF THE SEBACEOUS GLANDS. | | | | | | | | | | |
| Seborrhœa: | 10 | 2 | 12 | .. | .. | .. | .. | .. | 12 | .. |
| *a.* oleosa | 53 | 81 | 134 | 99 | 16 | 3 | 4 | 12 | .. | .. |
| *b.* sicca | 68 | 79 | 147 | 6 | 33 | 25 | 33 | 50 | .. | .. |
| Comedo | 13 | 127 | 140 | 32 | 23 | 14 | 8 | 52 | 11 | .. |
| Cyst: | 1 | 3 | 4 | .. | 4 | .. | .. | .. | .. | .. |
| *a.* Milium | 13 | 10 | 23 | 4 | 11 | 1 | .. | 2 | 5 | .. |
| *b.* Steatoma | 8 | 19 | 27 | 8 | 6 | 4 | 4 | 3 | 2 | .. |
| Asteatosis | 2 | . | 2 | 1 | .. | .. | .. | 1 | .. | .. |
| **Class II. Inflammations.** | | | | | | | | | | |
| Exanthemata | 90 | 47 | 137 | 10 | 24 | .. | 16 | 85 | 2 | .. |
| Erythema simplex | 43 | 50 | 93 | 23 | 14 | 3 | 6 | 46 | 1 | .. |
| Erythema multiforme | 7 | 39 | 46 | .. | 46 | .. | .. | .. | .. | .. |
| *a.* papulosum | 26 | 67 | 93 | 33 | .. | 15 | 7 | 36 | 2 | .. |
| *b.* bullosum | 1 | 4 | 5 | 2 | .. | 1 | .. | 2 | .. | .. |
| *c.* nodosum | 5 | 16 | 21 | 4 | 5 | 1 | 2 | 9 | .. | .. |
| Urticaria | 57 | 304 | 361 | 98 | 106 | 64 | 37 | 38 | 18 | .. |
| pigmentosa | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |

*TABLE II.—Continued.*

| | Private Practice. | Public Practice. | Total. | Boston. | New York. | Philadelph. | Baltimore. | Chicago. | St. Louis. | Canada. |
|---|---|---|---|---|---|---|---|---|---|---|
| Dermatitis :[1] | 1 | 75 | 76 | 32 | 13 | 31 | .. | .. | .. | .. |
| *a.* traumatica | 26 | 84 | 110 | 27 | 35 | 2 | 13 | 28 | 5 | .. |
| *b.* venenata | 25 | 135 | 160 | 54 | 34 | 27 | 22 | 21 | 2 | .. |
| *c.* calorica | 10 | 31 | 41 | 2 | 23 | 1 | 6 | 7 | 2 | .. |
| *d.* medicamentosa | 21 | 14 | 35 | 2 | 9 | 3 | .. | 20 | 1 | .. |
| *e.* gangrænosa | 3 | .. | 3 | .. | .. | .. | .. | 3 | .. | .. |
| Erysipelas | 20 | 83 | 103 | 16 | 21 | 4 | 13 | 47 | 2 | .. |
| Furunculus | 68 | 112 | 180 | 31 | 49 | 8 | 20 | 59 | 13 | .. |
| Anthrax | 16 | 14 | 30 | 1 | 7 | .. | .. | 22 | .. | .. |
| Phlegmona diffusa | 2 | 14 | 16 | .. | 7 | 1 | 7 | 1 | .. | .. |
| Pustula maligna | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Herpes simplex | 120 | 155 | 275 | 103 | 35 | 28 | 8 | 86 | 15 | .. |
| Herpes zoster | 25 | 145 | 170 | 43 | 46 | 31 | 18 | 19 | 13 | .. |
| Dermatitis herpetiform | 4 | 9 | 13 | 7 | 4 | 1 | .. | 1 | .. | .. |
| Psoriasis | 113 | 349 | 462 | 139 | 134 | 53 | 37 | 75 | 24 | .. |
| Pityriasis maculata et circinata | 12 | 10 | 22 | 10 | 3 | 1 | .. | 8 | .. | .. |
| Dermatitis exfoliativa | 6 | 4 | 10 | 1 | 4 | .. | .. | 4 | 1 | .. |
| Pityriasis rubra | 1 | 5 | 6 | .. | 3 | .. | .. | 3 | .. | .. |
| Lichen : | .. | 2 | 2 | .. | .. | .. | 2 | .. | .. | .. |
| *a.* planus | 8 | 21 | 29 | 4 | 14 | .. | 2 | 7 | 2 | .. |
| *b.* ruber | 4 | .. | 4 | 1 | 3 | .. | .. | .. | .. | .. |
| Eczema : | 744 | 3279 | 4023 | 1276 | 1033 | 631 | 355 | 424 | 304 | .. |
| *a.* erythematosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *b.* papulosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *c.* vesiculosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *d.* madidans | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *e.* pustulosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *f.* rubrum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *g.* squamosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Prurigo | .. | 3 | 3 | .. | 1 | .. | 1 | 1 | .. | .. |
| Acne | 441 | 748 | 1189 | 343 | 423 | 126 | 78 | 134 | 85 | .. |
| Acne rosacea | 117 | 11 | 128 | 10 | 44 | 24 | 12 | 38 | .. | .. |
| Sycosis | 22 | 56 | 78 | 6 | 21 | 19 | 4 | 27 | 1 | .. |
| Impetigo | 27 | 219 | 246 | 86 | 103 | 15 | 4 | 38 | .. | .. |
| Impetigo contagiosa | 6 | 40 | 46 | 10 | 5 | 12 | 5 | 14 | .. | .. |
| Impetigo herpetiformis | .. | 1 | 1 | .. | 1 | .. | .. | . | .. | .. |
| Ecthyma | 4 | 79 | 83 | 10 | 14 | 18 | 1 | 36 | 4 | .. |
| Pemphigus | 3 | 9 | 12 | 1 | 1 | 1 | 2 | 7 | .. | .. |
| Ulcer, simple | .. | 35 | 35 | .. | .. | .. | .. | 35 | .. | .. |
| **Class III. Hæmorrhages.** | | | | | | | | | | |
| Purpura : | .. | 2 | 2 | .. | 2 | . | .. | .. | .. | .. |
| *a.* simplex | 12 | 37 | 49 | 11 | 5 | 10 | 2 | 16 | 5 | .. |
| *b.* hæmorrhagica | 1 | 10 | 11 | 1 | 8 | .. | 1 | 1 | .. | .. |
| **Class IV. Hypertrophies.** | | | | | | | | | | |
| 1. Of Pigment. | | | | | | | | | | |
| Lentigo | 9 | 6 | 15 | 2 | 3 | .. | 1 | 4 | 5 | .. |
| Chloasma | 27 | 39 | 66 | 20 | 15 | 6 | 6 | 9 | 10 | .. |

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[1] Indicating affections of this class not properly included under other titles.

*TABLE II.—Continued.*

| | Private Practice. | Public Practice. | Total. | Boston. | New York. | Philadelph. | Baltimore. | Chicago. | St. Louis. | Canada. |
|---|---|---|---|---|---|---|---|---|---|---|
| 2. OF EPIDERMAL AND PAPILLARY LAYERS. | | | | | | | | | | |
| Keratosis | .. | 1 | 1 | .. | .. | .. | 1 | .. | .. | .. |
| *a.* pilaris | 10 | 20 | 30 | 7 | 11 | 2 | .. | 5 | 5 | .. |
| *b.* senilis | 8 | 12 | 20 | 11 | 3 | 2 | .. | 1 | 3 | .. |
| Molluscum epitheliale | 1 | 18 | 19 | 3 | 12 | 2 | 1 | 1 | .. | .. |
| Callositas | 11 | 10 | 21 | 2 | 7 | 3 | 2 | 5 | 2 | .. |
| Clavus | 2 | 10 | 12 | .. | 4 | 3 | 1 | .. | 4 | .. |
| Cornu cutaneum | 2 | 5 | 7 | .. | .. | 4 | .. | 3 | .. | .. |
| Verruca | 68 | 104 | 172 | 52 | 38 | 4 | 24 | 49 | 5 | .. |
| Verruca necrogenica | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Nævus pigmentosus | 30 | 6 | 36 | 3 | 6 | .. | 1 | 11 | 15 | .. |
| Xerosis | 3 | 5 | 8 | 6 | 1 | .. | 1 | .. | .. | .. |
| Ichthyosis | 12 | 29 | 41 | 1 | 17 | 10 | 4 | 8 | 1 | .. |
| Onychauxis | 1 | 2 | 3 | .. | 2 | .. | .. | 1 | .. | .. |
| Hypertrichosis | 52 | 10 | 62 | 14 | 10 | 1 | .. | 19 | 18 | .. |
| 3. OF CONNECTIVE TISSUE | | | | | | | | | | |
| Sclerema neonatorum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Scleroderma | 2 | 2 | 4 | 2 | 1 | .. | .. | 1 | .. | .. |
| Morphœa | 3 | 1 | 4 | 1 | 1 | .. | .. | .. | 2 | .. |
| Elephantiasis | 2 | 5 | 7 | .. | 4 | 1 | 2 | .. | .. | .. |
| Rosacea: | .. | 33 | 33 | .. | 33 | .. | .. | .. | .. | .. |
| *a.* erythematosa | 46 | 36 | 82 | 23 | 16 | 3 | .. | 32 | 8 | .. |
| *b.* hypertrophica | 2 | 3 | 5 | .. | 1 | 1 | .. | 3 | .. | .. |
| Frambœsia | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Ainhum | .. | 2 | 2 | .. | .. | .. | 2 | .. | . | .. |
| **Class V. Atrophies.** | | | | | | | | | | |
| 1. OF PIGMENT. | | | | | | | | | | |
| Leucoderma | 5 | 2 | 7 | 4 | .. | .. | .. | 1 | 2 | .. |
| Albinismus | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Vitiligo | 8 | 14 | 22 | 6 | 1 | 4 | 5 | 6 | .. | .. |
| Canities | 5 | 1 | 6 | 2 | 2 | 1 | .. | .. | 1 | .. |
| 2. OF HAIR. | | | | | | | | | | |
| Alopecia | 86 | 26 | 112 | 44 | 23 | 4 | 7 | 24 | 10 | . |
| Alopecia furfuracea | 58 | 33 | 91 | 59 | 11 | 16 | .. | 5 | .. | .. |
| Alopecia areata | 55 | 46 | 101 | 43 | 29 | .. | 3 | 19 | 7 | .. |
| Atrophia pilor'm prop'a | 2 | 1 | 3 | .. | 3 | .. | .. | .. | .. | .. |
| Trichorexis nodosa | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| 3. OF NAIL. | | | | | | | | | | |
| Atrophia unguis | 6 | 6 | 12 | 4 | 3 | .. | .. | 3 | 2 | .. |
| 4. OF CUTIS. | | | | | | | | | | |
| Atrophia senilis | 1 | 1 | 2 | .. | .. | .. | .. | 2 | .. | .. |
| Atrophia maculosa et striata | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| **Class VI. New Growths.** | | | | | | | | | | |
| 1. OF CONNECTIVE TISSUE | | | | | | | | | | |
| Keloid | 3 | 10 | 13 | .. | 3 | 4 | 3 | 3 | .. | .. |
| Cicatrix | 2 | 1 | 3 | 1 | .. | .. | .. | 2 | .. | .. |
| Fibroma | 4 | 7 | 11 | .. | 3 | .. | 5 | .. | 3 | .. |
| Neuroma | 1 | .. | 1 | .. | .. | .. | .. | .. | 1 | .. |
| Xanthoma | 3 | 2 | 5 | .. | 2 | .. | .. | 1 | 2 | .. |

*TABLE II.—Continued.*

| | Private Practice. | Public Practice. | Total. | Boston. | New York. | Philadelph. | Baltimore. | Chicago. | St. Louis. | Canada. |
|---|---|---|---|---|---|---|---|---|---|---|
| 2. OF MUSCULAR TISSUE. | | | | | | | | | | |
| Myoma | .. | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. |
| 3. OF VESSELS. | | | | | | | | | | |
| Angioma | 41 | 23 | 64 | 8 | 19 | 2 | 4 | 21 | 10 | .. |
| Angioma pigmentosum et atrophicum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Angioma cavernosum | 1 | 1 | 2 | .. | 2 | .. | .. | .. | .. | .. |
| Lymphangioma | .. | 1 | 1 | .. | 1 | .. | .. | .. | .. | .. |
| 4. Mycosis fungoides | .. | 1 | 1 | 1 | .. | .. | .. | .. | .. | .. |
| Rhino-scleroma | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Lupus erythematosus | 21 | 31 | 52 | 12 | 11 | 5 | .. | 21 | 3 | .. |
| Lupus vulgaris | 28 | 47 | 75 | 8 | 24 | 2 | 7 | 24 | 10 | .. |
| Scrofuloderma | 12 | 87 | 99 | 27 | 27 | 7 | 29 | 9 | .. | .. |
| Syphiloderma : | 372 | 1250 | 1622 | 419 | 432 | 124 | 163 | 433 | 51 | .. |
| *a.* erythematosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *b.* papulosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *c.* pustulosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *d.* tuberculosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *e.* gummatosum | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Lepra : | | | | | | | | | | |
| *a.* tuberosa | 1 | 1 | 2 | .. | 1 | .. | .. | 1 | .. | .. |
| *b.* maculosa | 1 | 1 | 2 | .. | 1 | .. | .. | 1 | .. | .. |
| *c.* anæsthetica | 1 | .. | 1 | 1 | .. | .. | .. | .. | .. | .. |
| Carcinoma | 69 | 95 | 164 | 35 | 43 | 18 | 8 | 57 | 3 | .. |
| Sarcoma | 6 | 2 | 8 | 4 | 1 | .. | .. | 2 | 1 | .. |
| **Class VII.—Neuroses.** | | | | | | | | | | |
| Hyperæsthesia : | | | | | | | | | | |
| *a.* Pruritus | 106 | 185 | 291 | 75 | 39 | 39 | 27 | 85 | 26 | .. |
| *b.* Dermatalgia | 1 | .. | 1 | .. | 1 | .. | .. | .. | .. | .. |
| Anæsthesia | 2 | .. | 2 | .. | .. | .. | .. | 2 | .. | .. |
| **Class VIII.—Parasitic Affections.** | | | | | | | | | | |
| 1. VEGETABLE. | | | | | | | | | | |
| Tinea favosa | 5 | 33 | 38 | 2 | 12 | 3 | .. | 20 | 1 | .. |
| Tinea trichophytina : | | | | | | | | | | |
| *a.* circinata | 55 | 184 | 239 | 100 | 42 | 26 | 21 | 43 | 7 | .. |
| *b.* tonsurans | 34 | 173 | 207 | 31 | 54 | 42 | 35 | 20 | 25 | .. |
| *c.* sycosis | 27 | 53 | 80 | 26 | 19 | 10 | 3 | 21 | 1 | .. |
| Tinea versicolor | 41 | 100 | 141 | 24 | 42 | 19 | 10 | 31 | 15 | .. |
| 2. ANIMAL. | | | | | | | | | | |
| Scabies | 49 | 393 | 442 | 224 | 36 | 44 | 8 | 56 | 74 | .. |
| Pediculosis capillitii | 5 | 267 | 272 | 137 | 50 | 32 | 16 | 24 | 13 | .. |
| Pediculosis corporis | 1 | 132 | 133 | 31 | 35 | 24 | 10 | 27 | 6 | .. |
| Pediculosis pubis | 23 | 22 | 45 | 18 | 6 | .. | .. | 20 | 1 | .. |
| Total | 3737 | 10270 | 14007 | 4054 | 3596 | 1662 | 1132 | 2675 | 888 | ... |

An examination of the tables given above discloses the fact that 14,007 cases of cutaneous disease are reported for the year ending June 30, 1885, as against 9,329 for the previous twelve months, the increase of

4,578 being largely due to fuller returns from the Boston district, which are by 1,826 larger than for the preceding year. This may be explained by the absence during that year of some contributors of statistics, members of this Association. The remainder of the increase is distributed between New York, Chicago, and St. Louis; the increase in these districts varying from 261 to 359.

No cases of the following-named diseases have been reported for the year: pustula maligna, chromidrosis, uridrosis, urticaria pigmentosa, trichorhexis nodosa, framboesia, rhinoscleroma, atrophiæ maculatæ et striatæ, scleroderma neonatorum, and albinismus.

Of the rarer diseases, 10 cases of dermatitis exfoliativa are reported from New York and Chicago; 4 of lichen ruber from New York and Boston; 3 of prurigo from New York, Chicago, and Baltimore; 1 of impetigo herpetiformis from New York; 2 of ainhum from Baltimore; 1 of myoma from New York; 1 of neuroma from St. Louis; 1 of lymphangioma from New York; and 1 of mycosis fungoides from Boston.

It is a matter of no little interest to note how uniformly, in proportion to the population, the more common diseases of the skin are recorded in the larger cities from year to year. With the material at hand, furnished by the accumulated statistics of years, one can predict within limits relatively fixed and with reasonable certainty, the amount and character of dispensary material that can be supplied by each ten thousand of inhabitants; and the number of cases that will fall under the observation of an expert of wide reputation, constantly attending to dermatological practice, who makes proper use of his opportunities. The variations are not markedly suggestive.

Baltimore, for example, reports the largest number of cases of fibroma, scrofuloderma, pediculosis pubis, and ainhum—facts certainly pointing to a large negro attendance upon the clinics. The Philadelphia records are, as usual, less valuable than the others, because the members of the Association from that city do not include in their statistics the records of their private practice. This year they excel only in the item of keloid. St. Louis reports the largest number of cases of nævus pigmentosus.

Boston largely exceeds in the item of alopecia and alopecia furfuracea, the figures set opposite these diseases being very nearly equal to all the cases reported from all the other districts together. They have also excelled in the preponderance of alopecia areata and tinea circinata.

New York reports the largest number of cases of sudamen, urticaria, dermatitis traumatica, dermatitis calorica, herpes zoster, acne, tinea tonsurans, tinea versicolor, impetigo, molluscum epitheliale, callositas, lichen planus, and pediculosis corporis.

Chicago excels in the number of both lupus erythematosus and lupus vulgaris, hypertrichosis, angioma, carcinoma, pruritus, and syphilis; in the latter item exceeding the number reported from New York by one merely.

The total number of cases of scabies reported is regularly increasing. Against 339 observed last year, we register this year 442; Boston coming within three of reporting one-half of the entire number. Attention was called to this increase in a note furnished by one of the contributors to the last report.

Four cases of lepra are reported, two each from the New York and Chicago districts. The anæsthetic case in the Chicago district is reported from the observation of Dr. Hoech, a Scandinavian physician, who has made an exceedingly thorough search for all the Scandinavian lepers in the Northwest. The second is represented by a resident of Chicago, whom I actually found in my waiting-room one morning, seated quietly with other patients, waiting his turn for an audience. As the case has peculiar features of interest, I append a brief note regarding it:

### NOTE RELATIVE TO CASE OF LEPRA TUBEROSA.

A. C. Lindberg, native of Wermland, in Sweden, aged 62 years, and now resident of Chicago, applied for advice June 10, 1885.

He had been by occupation a laborer, in the shops of one of the large railroad corporations.

He gave the following history: Father dead at 70; mother, at 75. One brother living, aged 30; two sisters living between ages of 30 and 40. All these lived in good health.

His wife, being examined, gave history as follows: She had never menstruated before the 20th year, when she suddenly suffered from severe epistaxis, and lost the bones of the nose. She married Lindberg in her 24th year, and one year after the marriage the two came to this country as emigrants. She first miscarried in the fifth week, as the result of an accident. A third pregnancy resulted in birth of a healthy child; dead in the third month of life after exposure to cold. But between these was born a boy, now living, and, when examined, found to be in sound health. She is a thin, cachectic-looking woman about 38 years of age, with flattening of the nose from loss of the nasal bones, and complains greatly of weakness and of menstruation recurring every two weeks. She is now supporting her husband by working as a laundress. Neither mother nor child present the slightest evidence of infection with the father's disease.

One year after his marriage he came to America, and settled first for three years in Northern Indiana, where he associated chiefly with people of his own nationality. Then he came to the city of Chicago, where he has since lived, always in the part of the city where he now resides. He refers all of his present troubles to exposure while laboring in a sewer which he was cleaning for a railway company four years ago. He thinks that then his "blood was poisoned," and he states that he has not been well since. He complains chiefly of the unwieldiness of his feet and hands, of loss of sleep at night, anorexia, irregular bowel-movement, pricking and burning sensations in the extremities, and a feeling as though the left foot and ankle "went to sleep." On close questioning, he admits that it is possible that the lumps now visible on the forehead may have been there longer than four years.

When examined, he was found to present the characteristic and typical leonine facies of lepra tuberosa, due to the presence of dull-colored and glazed tubercles on the brows, and to a deforming infiltration of the skin covering the alæ of the nose, the temples, and other parts of the face. Pigmented, bronzed, and decolorized patches of skin, irregularly anæsthetic, as tested by the æsthesiometer, were visible on the trunk, especially over the dorsum, in broad streaks running parallel to the line of the spinous processes, and also over the extremities, especially the thighs and the upper arms.

The hands and feet are unwieldly in consequence of the tumefaction produced by the presence of large numbers of split-pea to marble-sized tubercles, between which the skin is infiltrated. All these parts are of a dull-red, almost glazed hue.

The soft palate, especially on the right, is studded with split-pea-sized tubercles. Larynx not involved. Organs of sense unimpaired. Mental condition apathetic.

On June 23, patient was stripped and carefully examined by Dr. Christian Fenger and myself, the former concurring in the diagnosis.

August 2, he was stripped and thoroughly examined by Dr. O. C. DeWolf, the Health Commissioner of the city of Chicago, and myself, again confirming the diagnosis.

August 6, a large-sized tubercle was excised from the arm, and the scrapings of this, with sections of the same, examined microscopically, after fuchsine staining. Characteristic bacilli lepræ were recognized in large numbers, both in sections and in scrapings of this tissue.

August 16.—This last observation of the patient was made to consider the question of his isolation from the community and his separation from wife and child.

Slides, exhibiting the bacilli recognized in this case, after fuchsine staining, prepared by Mr. A. J. Ochsner, of Chicago, are herewith submitted.

James Nevins Hyde,
*Chairman of Committee.*

## A LIST OF THE CONTRIBUTIONS TO DERMATOLOGY

### PUBLISHED BY MEMBERS OF THE ASSOCIATION DURING THE YEAR ENDING SEPTEMBER 1, 1885.

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ALEXANDER. "Notes on the Treatment of an Epidemic of Ringworm of the Scalp in a Public Institution." *Journal of Cutaneous and Venereal Diseases,* February, 1885.

BULKLEY. "A Treatise on Acne." G. P. Putnam's Sons. New York, 1885.

DENSLOW. "Lupus Erythematosus." *Northwestern Lancet,* October 1, 1884.—"The Parasitic Diseases of the Skin, with Especial Reference to their Diagnosis and Treatment." *Ibid.,* November 15, 1884, December 1, 1884, and January 1, 1885.—"Persistent Headache in Early Syphilis, its Importance and Treatment." *Ibid.,* May 1, 1885.

DUHRING. "Notes of a Case of Dermatitis Herpetiformis, Extending over Eleven Years, illustrating the Several Varieties of the Disease." *Philadelphia Medical Times,* August 12, 1884.—"Case of Dermatitis Herpetiformis (Multiformis) Aggravated by Pregnancy and Irregular Menstruation." *The Medical News,* August 19, 1884.—"A Case of Dermatitis Herpetiformis (Bullosa)." *New York Medical Journal,* July 19, 1884.—"Case of Dermatitis Herpetiformis, illustrating in particular the Pustular Variety (Impetigo Herpetiformis of Hebra)." *Journal of Cutaneous and Venereal Diseases,* Vol. II., No. 8.—"Dermatitis Herpetiformis; its Relation to the so-called Impetigo Herpetiformis." *American Journal of the Medical Sciences,* October, 1884.—"Notes of a Case of Dermatitis Herpetiformis During Thirteen Years." *New York Medical Journal,* November 15, 1884.—"Preliminary Note on the Relation of Dermatitis Herpetiformis to Herpes Gestationis and other Similar Forms of Disease." *Medical News,* November 22, 1884.—"Case of Dermatitis Caused by Nervous Shock." *American Journal of the Medical Sciences,* January, 1885.—"Case of Dermatitis Herpetiformis with Peculiar Gelatinous Lesions." *The Medical News,* March 7, 1885.

GRAHAM. "A Case of Circumscribed Cutaneous Œdema."—"Recurrent Dermatitis Exfoliativa." Both in *Canadian Practitioner.*

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HYDE. "A Clinical Study of Lupus Erythematosus as it Affects the Hands." *Journal of Cutaneous and Venereal Diseases,* November, 1884.—"On the Affections of the Skin Induced by Temperature Changes in Cold Weather." *Chicago Medical Journal and Examiner,* 1885.—"A Case of Congenital Nævus Lipomatodes, illustrated by Colored Lithograph and Woodcut." *Journal of Cutaneous and Venereal Diseases,* July, 1885.

MORISON. "Notes on a Case of Elephantiasis of the Forearm." *Maryland Medical Journal,* February 21, 1885. "Ergebnisse der Behandlung von Hautkrankheiten mit Unna'schen Präparaten." *Deutsche Medicinische Wochenschrift,* No. 21, 1885.—"Prof. Unna's Plasters in the Treatment of Skin Diseases." *Medical News,* June 13, 1885.

ROBINSON. "Hydroa (Dermatitis Herpetiformis)."—"Manual of Dermatology." Bermingham & Co., New York, 1884.

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TAYLOR. "On a Peculiar Ringed Affection of the Prepuce and Glans." *Archives of Medicine,* December, 1884.—"On the Pigmentary Syphilide." *Journal of Cutaneous Medicine,* May, 1885.

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